ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF CHILD CARE LICENSURE

I, _____, give permission to Sandy or Nelleke to administer _____ of
(Parent or Guardian) (Dose)
_____ by _____ RX#_____ to my child, _____
(Name of Medication) (Route of Administration) (First and Last Name of Child)
at _____ from _____ to _____ for _____
(Time and Frequency) (date) (date) (Reason for Medication)

**POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:**_____
_____

**Injections: Attach physician's written authorization**

_____
(Signature of Parent) (Date)

**STAFF USE, PRIOR TO ADMINISTERING MEDICATION:**

Y or N Is the permission form complete?
Y or N Is the original prescription label on the medication container or pre packaged and labeled for use by manufacturer?
Y or N Is the full name of the child on the container?
Y or N Is the prescription or over-the-counter medication current?
Y or N Is the dose, name of drug, frequency of administration given on label consistent with instructions above?

| Date | Medication and Rx # | Dose | Time | Full Signature-Authorized Staff Person |
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Child's Name _____

| Date | Medication and Rx # | Dose | Time | Full Signature-Authorized Staff Person |
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Child's Name_______________________________________________________________